

## Appendix 9

### Sample Prior Authorization Request Form (PA/RF)

<b>MAIL TO:</b> E.D.S. FEDERAL CORPORATION PRIOR AUTHORIZATION UNIT 6406 BRIDGE ROAD SUITE 88 MADISON, WI 53784-0088				<b>PRIOR AUTHORIZATION REQUEST FORM</b> <div style="border: 1px solid black; display: inline-block; padding: 2px;">PA/RF</div> (DO NOT WRITE IN THIS SPACE)  ICN # A.T. # P.A. # <b>1223334</b>				<b>1 PROCESSING TYPE</b>  <div style="border: 1px solid black; display: inline-block; padding: 5px; font-size: 1.2em;">999</div>			
2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER <b>1234567890</b>						4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE) <b>609 Willow Anytown, WI 55555</b>					
3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL) <b>Recipient, Ima A.</b>						8 BILLING PROVIDER TELEPHONE NUMBER ( XXX ) XXX-XXXX					
5 DATE OF BIRTH <b>MM/DD/YY</b>				6 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>		9 BILLING PROVIDER NO. <b>12345678</b>				10 DX: PRIMARY <b>00025</b>	
7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE:  <b>I.M. Provider 1 W. Williams Anytown, WI 55555</b>						11 DX: SECONDARY				12 START DATE OF SOI:	
										13 FIRST DATE RX: <b>3-31-2002</b>	
14	15	16	17	18			19	20			
PROCEDURE CODE	MOD	POS	TOS	DESCRIPTION OF SERVICE			QR	CHARGES			
<b>00025</b>	<b>TH</b>	<b>3</b>	<b>9</b>	<b>SMV Mileage</b>			<b>60</b>	<b>XXX.XX</b>			
							TOTAL CHARGE	21		<b>XXX.XX</b>	

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 <b>MM/DD/YY</b>	24 <i>I.M. Provider</i>	REQUESTING PROVIDER SIGNATURE
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(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:  <input type="checkbox"/> APPROVED  <input type="checkbox"/> MODIFIED REASON: _____  <input type="checkbox"/> DENIED REASON: _____  <input type="checkbox"/> RETURN REASON: _____	<div style="border: 1px solid black; width: 100px; height: 20px; margin: 0 auto;"></div> GRANT DATE	<div style="border: 1px solid black; width: 100px; height: 20px; margin: 0 auto;"></div> EXPIRATION DATE	PROCEDURE(S) AUTHORIZED	QUANTITY AUTHORIZED
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DATE	CONSULTANT/ANALYST SIGNATURE
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